

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5613 62-021159
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED JUN 15 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP.#1</u>		d. STREET ADDRESS (If outside, give location) <u>3815 CALIFORNIA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>WIETHOP</u> Last	4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1962</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/1883</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LEATHER STRIPPER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SUNSHINE SHOE CO</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>LOUIS</u>	13b. MOTHER'S MAIDEN NAME <u>SOPHIA NEEP</u>	14. NAME OF HUSBAND OR WIFE <u>LILLIE DECEASED</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>NO</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>87 JULIE - STUCKENBERG 2819 SIDNEY</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage into brain stem</u>	INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>	DUE TO (c) <u>331X</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>am</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>ST. LOUIS</u> COUNTY <u>MO</u> STATE
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21. I attended the deceased from <u>5-31-62</u> to <u>6-4-62</u> and last saw <u>him</u> alive on <u>6-4-62</u> Death occurred at <u>12:55 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Daniel D. Hellman MD</u> (Degree or title)	22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	22c. DATE SIGNED <u>6/4/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JUNE 6 - 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL G MURCH YARD</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS - CO. MO</u>
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24. FUNERAL DIRECTOR <u>SCHUMACHER FUNERAL HOME, INC.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 5 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

HELLMAN

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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2 224
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5 2
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7 0
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75

DATE AMENDED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

W E Morris

Licensed Embalmer No. 3360

P. O. Address

St Louis *MO*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.